Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
758175			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change ***Complete Beneficiary Section below.*** ☐ Name Change
☐ Add or ☐ Delete Dependent Date of add/delete_____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female
Your Address		City	State / ZIP
Former Name (Last, First, Middle) *Complete only if name change*		Phone Number	
Employer Name **Pensacola State College**		Job Title/Occupation	
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year		

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

Life Insurance

☒ Basic Life with AD&D $50,000 (Employer Paid)

The following options are available if you have a qualifying salary.

☐ Basic Life with AD&D plus $25,000 (Employee Paid)

☐ Basic Life with AD&D plus $50,000 (Employee Paid)

Additional Life with AD&D (Employee Paid)

☐ Annual Earnings multiplied by 1 **OR** ☐ Annual Earnings multiplied by 2 **OR** ☐ Annual Earnings multiplied by 3

Dependents Life Insurance

☐ Basic Spouse Life $20,000 / Basic Child(ren) Life $10,000 (Employee Paid)

Beneficiary ***This designation applies to your Life and Accidental Death and Dismemberment Insurance and Voluntary Accidental Death and Dismemberment Insurance, if any, available through your Employer. Designations made below or on a separate sheet of paper are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.***

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Total must equal 100%

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form to your Human Resources Department.